		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045526

Facility Name: PRESIDENTIAL PAVILION

Address: 8001 S. WESTERN AVENUE (Number) CHICAGO (City) 60620 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-4465311

Date of Initial License for Current Owners: 10/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	218	Skilled (SNF)	218	79,788	1
2		Skilled Pediatric (SNF/PED)			2
3	110	Intermediate (ICF)	110	40,260	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	120,048	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	38,153	533	19,359	58,045	8
9	SNF/PED					9
10	ICF	60,844	531	12	61,387	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	98,997	1,064	19,371	119,432	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.49%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 19,351

Medicare Intermediary BLUE CROSS-BLUE SHIELD

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	322,593	34,952	15,491	373,036		373,036		373,036			1
2	Food Purchase		428,813		428,813	(12,627)	416,186	(3,712)	412,474			2
3	Housekeeping	341,014	35,460		376,474		376,474		376,474			3
4	Laundry	130,487	22,362	6,256	159,105		159,105	330	159,435			4
5	Heat and Other Utilities			250,819	250,819		250,819	815	251,634			5
6	Maintenance	266,202	62,351	96,887	425,440		425,440	9,422	434,862			6
7	Other (specify):*			26,156	26,156		26,156	145	26,301			7
8	**TOTAL General Services**	1,060,296	583,938	395,609	2,039,843	(12,627)	2,027,216	7,000	2,034,216			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,584,325	98,424	42,618	3,725,367		3,725,367		3,725,367			10
10a	Therapy	115,388		53,652	169,040		169,040		169,040			10a
11	Activities	171,253	52,348	4,608	228,209		228,209		228,209			11
12	Social Services	211,873		4,046	215,919		215,919		215,919			12
13	Nurse Aide Training											13
14	Program Transportation			25	25		25		25			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,082,839	150,772	110,949	4,344,560		4,344,560		4,344,560			16
	C. General Administration											
17	Administrative	177,917		1,033,000	1,210,917		1,210,917	(915,099)	295,818			17
18	Directors Fees											18
19	Professional Services			69,581	69,581		69,581	12,861	82,442			19
20	Dues, Fees, Subscriptions & Promotions			35,974	35,974		35,974	(6,833)	29,141			20
21	Clerical & General Office Expenses	259,524	23,571	181,464	464,559		464,559	(169,048)	295,511			21
22	Employee Benefits & Payroll Taxes			893,391	893,391	12,627	906,018		906,018			22
23	Inservice Training & Education							133	133			23
24	Travel and Seminar			1,760	1,760		1,760		1,760			24
25	Other Admin. Staff Transportation			9,494	9,494		9,494	1,340	10,834			25
26	Insurance-Prop.Liab.Malpractice			172,407	172,407		172,407	1,041	173,448			26
27	Other (specify):*			495,989	495,989		495,989	(485,685)	10,304			27
28	**TOTAL General Administration**	437,441	23,571	2,893,060	3,354,072	12,627	3,366,699	(1,561,290)	1,805,409			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,580,576	758,281	3,399,618	9,738,475		9,738,475	(1,554,290)	8,184,185			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: PRESIDENTIAL PAVILION **#0045526** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	15,491	
	REPAIRS & MAINTENANCE		0	
			0	15,491
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		6,256	
			0	6,256
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		99,681	
	ELECTRICITY		115,858	
	WATER		35,280	
	CABLE TV - LOBBY		0	
			0	250,819
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,585	
	PAINTING & DECORATING		581	
	BUILDING REPAIRS		828	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		40,441	
	ELEVATOR MAINTENANCE & REPAIR		23,548	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		8,125	
	FIRE SERVICE		20,779	
			0	
			0	
			0	96,887
7	**OTHER**			
	SCAVENGER		26,156	
	SECURITY SERVICE		0	26,156
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		21,227	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,512	
	PHARMACY CONSULTANT	XVIII B 39-2	9,479	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	6,000	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL CONSULTANT		4,400	
			0	42,618
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	8,322	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,330	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	40,000	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	53,652
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,608	
			0	4,608
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	4,046	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	4,046
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PRESIDENTIAL PAVILION **#0045526** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		25	25
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	1,033,000	1,033,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,449	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	50,132	
			0	69,581
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,273	
	EMPLOYEE WANT ADS	XIX F	1,500	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	10,390	
	LICENSES & PERMITS	XIX F	9,656	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,936	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	5,719	35,974
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		5,611	
	OUTSIDE CLERICAL SERVICES		75,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	7,817	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		25,803	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		67,233	181,464

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	412,984	
	UNEMPLOYMENT COMPENSATION	XIX D	95,015	
	WORKERS COMPENSATION INSURANCI	XIX D	155,214	
	HOSPITALIZATION INSURANCE	XIX D	173,739	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,253	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	39,202	
	CHICAGO HEAD TAX	XIX D	12,984	893,391
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,760	
	TRAVEL	XIX G	0	
			0	
			0	1,760
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,494	9,494
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		172,407	172,407
27	**OTHER**			
	BAD DEBTS	VI 24	495,989	
				495,989

GRAND TOTAL COLUMN 3 OTHER 3,399,618

PRESIDENTIAL PAVILION
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	428,813	PATIENT MEALS	358296
LESS SALES TAX	(3,712)	ADD EMPLOYEE MEALS	10980
NET FOOD	425,101	TOTAL MEALS/YEAR	369276
TOTAL PATIENT CENSUS	119,432	NET FOOD	425101
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	369276
TOTAL PATIENT MEALS	358296	COST PER MEAL	1.15
		TIME EMPLOYEE MEALS	10980
ADD # EMPLOYEE MEALS/DAY	30		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	12627
TOTAL EMPLOYEE MEALS	10980		

Facility Name & ID Number PRESIDENTIAL PAVILION #0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			126,742	126,742		126,742	(22,334)	104,408			30
31	Amortization of Pre-Op. & Org.			780	780		780		780			31
32	Interest			17,854	17,854		17,854	2,703	20,557			32
33	Real Estate Taxes			317,768	317,768		317,768	3,496	321,264			33
34	Rent-Facility & Grounds			1,555,650	1,555,650		1,555,650		1,555,650			34
35	Rent-Equipment & Vehicles			63,728	63,728		63,728	9,604	73,332			35
36	Other (specify):* IME RENT			25,584	25,584		25,584	(25,584)				36
37	**TOTAL Ownership**			2,108,106	2,108,106		2,108,106	(32,115)	2,075,991			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		252,055	451,449	703,504		703,504		703,504			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,072	180,072		180,072		180,072			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		252,055	631,521	883,576		883,576		883,576			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,580,576	1,010,336	6,139,245	12,730,157		12,730,157	(1,586,405)	11,143,752			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(25,319)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,712)	2		13
14	Non-Care Related Interest	(543)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(7,817)	21		18
19	Entertainment		20		19
20	Contributions	(6,436)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(495,989)	27		24
25	Fund Raising, Advertising and Promotional	(2,273)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(575,449)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,117,538)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(468,867)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (468,867)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,586,405)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PRESIDENTIAL PAVILION

ID# 0045526

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 3483	6	1
2	MARKETING SALARIES	(80,199)	21	2
3	STAFF DEVELOPMENT	(67,233)	21	3
4	PHILIP ESFORMES, INC MANAGEMENT FEES	(431,500)	17	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(575,449)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,712)	0	0	0	0	0	0	0	0	0	0	(3,712)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	330	0	0	0	0	0	0	0	0	330	4
5	Heat and Other Utilities	0	0	0	815	0	0	0	0	0	0	0	815	5
6	Maintenance	3,483	0	3,878	2,061	0	0	0	0	0	0	0	9,422	6
7	Other (specify):*	0	0	58	87	0	0	0	0	0	0	0	145	7
8	**TOTAL General Services**	(229)	0	4,266	2,963	0	0	0	0	0	0	0	7,000	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(431,500)	(496,429)	12,830	0	0	0	0	0	0	0	0	(915,099)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	302	12,430	129	0	0	0	0	0	0	0	12,861	19
20	Fees, Subscriptions & Promotions	(8,709)	0	1,876	0	0	0	0	0	0	0	0	(6,833)	20
21	Clerical & General Office Expenses	(155,249)	14,622	(28,781)	360	0	0	0	0	0	0	0	(169,048)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	133	0	0	0	0	0	0	0	0	133	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	421	919	0	0	0	0	0	0	0	0	1,340	25
26	Insurance-Prop.Liab.Malpractice	0	0	613	428	0	0	0	0	0	0	0	1,041	26
27	Other (specify):*	(495,989)	2,015	8,289	0	0	0	0	0	0	0	0	(485,685)	27
28	**TOTAL General Administration**	(1,091,447)	(479,069)	8,309	917	0	0	0	0	0	0	0	(1,561,290)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,091,676)	(479,069)	12,575	3,880	0	0	0	0	0	0	0	(1,554,290)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(25,319)	0	490	2,495	0	0	0	0	0	0	0	(22,334)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(543)	0	0	3,246	0	0	0	0	0	0	0	2,703	32
33	Real Estate Taxes	0	0	0	3,496	0	0	0	0	0	0	0	3,496	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,218	8,139	247	0	0	0	0	0	0	0	9,604	35
36	Other (specify):*	0	0	0	(25,584)	0	0	0	0	0	0	0	(25,584)	36
37	**TOTAL Ownership**	(25,862)	1,218	8,629	(16,100)	0	0	0	0	0	0	0	(32,115)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,117,538)	(477,851)	21,204	(12,220)	0	0	0	0	0	0	0	(1,586,405)	45

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MNGT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISE	LINCOLNWOOD	MNGT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	EMI	$ 521,500	EMI ENTERPRISES, INC		$	$ (521,500)	1
2	V								2
3	V								3
4	V	17	OFFICER'S SALARY				25,071	25,071	4
5	V	19	ACCOUNTING FEES				302	302	5
6	V	21	OFFICE EXPENSE				14,622	14,622	6
7	V	25	TRANSPORTATION				421	421	7
8	V	26	INSURANCE						8
9	V	27	EMPLOYEE BENEFITS				2,015	2,015	9
10	V	35	AUTO LEASE				1,218	1,218	10
11	V								11
12	V								12
13	V								13
14	Total			$ 521,500			$ 43,649	$ * (477,851)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 75,000	EKS MANAGEMENT		$	$ (75,000)	15
16	V								16
17	V	4	HOUSEKEEPING SALARIES				330	330	17
18	V	6	PAINTERS SALARIES				3,878	3,878	18
19	V	7	SCAVENGER				58	58	19
20	V	17	C F O SALARY				12,830	12,830	20
21	V	19	PROFESSIONAL FEES				12,430	12,430	21
22	V	20	WANT ADS/ BACK GR CKS				1,876	1,876	22
23	V	21	OFFICE EXPENSE				46,219	46,219	23
24	V	23	SEMINARS				133	133	24
25	V	25	TRANSPORTATION				919	919	25
26	V	26	INSURANCE				613	613	26
27	V	27	EMPLOYEE BENEFITS				8,289	8,289	27
28	V	30	DEPRECIATION				490	490	28
29	V	35	EQUIPMENT RENT				8,139	8,139	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 75,000			$ 96,204	$ * 21,204	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 25,584	IME REALTY		$	$ (25,584)	15
16	V								16
17	V								17
18	V	5	UTILITIES				815	815	18
19	V	6	REPAIRS / MAINTENANCE				2,061	2,061	19
20	V	7	ALARM SERVICE				87	87	20
21	V	19	PROFEESIONAL FEES				129	129	21
22	V	21	OFFICE EXPENSE				360	360	22
23	V	26	INSURANCE				428	428	23
24	V	30	DEPRECIATION				2,495	2,495	24
25	V	32	INTEREST				3,246	3,246	25
26	V	33	R/E TAX				3,496	3,496	26
27	V	35	STORAGE FEES				247	247	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 25,584			$ 13,364	$ * (12,220)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	MEMBER	ADMIN.	40.00	SEE ATTACHED			MNMT FEE	$ 25,071	17-8	1
2											2
3	PHILIP ESFORMES	MEMBER	ADMIN.	40.00	SEE ATTACHED			MNMT FEE	80,000	17-8	3
4											4
5	ARUM WEINFELD		CFO	3.00					12,830	17-8	5
6											6
7											7
8	MICHAEL ROSEN	ADMINISTRATOR		3.00				SALARY	177,917	17-1	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 295,818		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARY	PATIENT DAYS	881,303	14	$ 185,000	$ 185,000	119,432	$ 25,071	1
2	19	ACCOUNTING FEES	PATIENT DAYS	881,303	14	2,230		119,432	302	2
3	21	OFFICE EXPENSE	PATIENT DAYS	881,303	14	107,899	87,197	119,432	14,622	3
4	25	TRANSPORTATION	PATIENT DAYS	881,303	14	3,109		119,432	421	4
5	26	INSURANCE	PATIENT DAYS	881,303	14				0	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	14,871		119,432	2,015	6
7	35	AUTO LEASE	PATIENT DAYS	881,303	14	8,991		119,432	1,218	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 322,100	$ 272,197		$ 43,649	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	881,303	14	$ 2,437	$ 2,437	119,432	$ 330	1
2	6	PAINTERS SALARY	PATIENT DAYS	881,303	14	28,615	28,615	119,432	3,878	2
3	7	SCAVENGER	PATIENT DAYS	881,303	14	429		119,432	58	3
4	17	C F O SALARY	PATIENT DAYS	881,303	14	94,671	94,671	119,432	12,830	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	881,303	14	91,723		119,432	12,430	5
6	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	881,303	14	13,841		119,432	1,876	6
7	21	OFFICE EXPENSE	PATIENT DAYS	881,303	14	341,059	251,740	119,432	46,219	7
8	23	SEMINARS	PATIENT DAYS	881,303	14	984		119,432	133	8
9	25	TRANSPORTATION	PATIENT DAYS	881,303	14	6,783		119,432	919	9
10	26	INSURANCE	PATIENT DAYS	881,303	14	4,521		119,432	613	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	61,166		119,432	8,289	11
12	30	DEPRECIATION	PATIENT DAYS	881,303	14	3,617		119,432	490	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	881,303	14	60,061		119,432	8,139	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 709,907	$ 377,463		$ 96,204	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	312,263	15	$ 9,942	$	25,584	$ 815	1
2	6	REPAIRS / MAINT	INCOME	312,263	15	25,152		25,584	2,061	2
3	7	ALARM SERVICE	INCOME	312,263	15	1,056		25,584	87	3
4	19	PROFESSIONAL FEES	INCOME	312,263	15	1,575		25,584	129	4
5	21	OFFICE EXPENSE	INCOME	312,263	15	4,388		25,584	360	5
6	26	INSURANCE	INCOME	312,263	15	5,225		25,584	428	6
7	30	DEPRECIATION	INCOME	312,263	15	30,446		25,584	2,495	7
8	32	INTEREST	INCOME	312,263	15	39,619		25,584	3,246	8
9	33	R/E TAX	INCOME	312,263	15	42,669		25,584	3,496	9
10	35	STORAGE FEES	INCOME	312,263	15	3,011		25,584	247	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 163,083	$		$ 13,364	25

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	RELATED PARTY										3,246	5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV		221,000	REVOLV	PRIME+	17,854	6
7												7
8												8
9	TOTAL Facility Related						$	$ 221,000			$ 21,100	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 221,000			$ 21,100	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 335,896	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 326,832	2
3. Under or (over) accrual (line 2 minus line 1).		$ (9,064)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 326,832	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 317,768	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001	83,725	10
2002	335,896	11
2003	326,832	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESIDENTIAL PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045526

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-31-108-044-0000	NURSING HOME	$ 326,831.59	$ 326,831.59
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 326,831.59	$ 326,831.59

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,056 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 7 + BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 3,900 2. Number of Years Over Which it is Being Amortized: 5 YRS

3. Current Period Amortization: 780 4. Dates Incurred: 10/01/01

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7	RELATED					2,397		2,397			7
8											8
	Improvement Type**										
9	AWNINGS			2001	10,500	382	27.5	382		1,194	9
10	FENCE			2001	2,100	140	15	140		438	10
11	ELEVATOR			2001	18,340	667	27.5	667		2,084	11
12	ALARM			2001	5,686	207	27.5	207		647	12
13	WINDOWS			2001	4,149	151	27.5	151		472	13
14	BOILER			2001	3,000	109	27.5	109		123	14
15	FURNISHINGWALLPAPER & BORDERS			2001	12,953	1,370	5	2,591	1,221	11,749	15
16	KITCHEN SINK & DRAIN			2001	2,525	92	27.5	92		287	16
17	DOORS			2001	15,100	549	27.5	549		1,705	17
18	ELEVATOR			2002	222,811	8,102	27.5	8,102		24,306	18
19	FENCE			2002	3,100	207	15	207		518	19
20	DOORS & LOCKS			2002	21,741	791	27.5	791		2,274	20
21	SHOWER ROOMS			2002	4,669	170	27.5	170		390	21
22	ALARM AND SPRINKLER			2002	11,881	432	27.5	432		989	22
23	EJECTOR & SEWEGE PUMP			2002	14,604	531	27.5	531		1,217	23
24	ROOF DRAIN			2002	3,100	113	27.5	113		287	24
25	FURNISHING - CARPETS AND DRAPERIES			2002	91,494	12,297	5	18,299	6,002	45,747	25
26	ELEVATIR			2003	110,562	4,020	27.5	4,020		7,203	26
27	PARKING LOT			2003	64,182	4,279	15	4,279		6,419	27
28	FIRE ALARM SYSTEM			2003	25,000	909	27.5	909		1,401	28
29	ROOF			2003	26,500	964	27.5	964		1,406	29
30	EXTERIOR WALL			2003	9,796	356	27.5	356		490	30
31	SINKS			2003	3,146	114	27.5	114		176	31
32	BUILT IN WARDROBE			2003	19,398	705	27.5	705		911	32
33	REBUILD A/C & HEATING RETURN FAN			2004	4,700	150	27.5	150		150	33
34	FIRE ALARM SYSTEM			2004	13,201	380	27.5	380		380	34
35	BUILT IN WARDROBE			2004	21,807	430	27.5	430		430	35
36	MASONRY REPAIRS			2004	61,620	654	27.5	654		654	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOORS	2004	$ 2,995	$ 23	27.5	$ 23	$	$ 23	37
38	BOILER REPAIR	2004	5,650	8	27.5	8		8	38
39	HOT WATER HEATER	2004	5,756	9	27.5	9		9	39
40	FLOOR TILING	2004	5,326	8	27.5	8		8	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 827,392	$ 41,716		$ 48,939	$ 7,223	$ 114,095	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 529,269	$ 63,973	$ 52,927	$ (11,046)	10 YR	$ 151,672	71
72	Current Year Purchases	39,083	23,450	1,954	(21,496)	10 YR	1,954	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		588	588		10 YR		74
75	TOTALS	$ 568,352	$ 88,011	$ 55,469	$ (32,542)		$ 153,626	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,395,744	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 129,727	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 104,408	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (25,319)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 267,721	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WEDGEWOOD NURSING PAVILION REALTY, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [x] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		328	10/01/01	$ 1,555,650			3
4	Additions							4
5								5
6								6
7	TOTAL		328		$ 1,555,650 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 10/01/01
Ending 09/30/08

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$ 1,555,650
13.	/2006	$ 1,555,650
14.	/2007	$ 1,555,650

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 16,828 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		SEE SCHEDULE	$	$ 46,900	17
18					18
19					19
20					20
21	TOTAL		$	$ 46,900	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 247,494	$		$ 247,494	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			36,151			36,151	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			167,654			167,654	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				230,701		230,701	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): med supplies, lab	39-8				150	21,354		21,504	13
14	TOTAL			$		$ 451,449	$ 252,055		$ 703,504	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 345,219	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 450,000)	2,955,742		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	141,293		6
7	Other Prepaid Expenses	85,390		7
8	Accounts Receivable (owners or related parties)	10,000		8
9	Other(specify): R.E. ESCROW	347,175		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,884,819	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	722,945		15
16	Equipment, at Historical Cost	672,799		16
17	Accumulated Depreciation (book methods)	(594,846)		17
18	Deferred Charges	11,000		18
19	Organization & Pre-Operating Costs	3,900		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,535)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spc Option Deposit	250,000		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,063,263	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,948,082	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 778,582	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	221,000		29
30	Accrued Salaries Payable	93,084		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,948		31
32	Accrued Real Estate Taxes(Sch.IX-B)	326,832		32
33	Accrued Interest Payable	4,061		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,446,507	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	314,500		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 314,500	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,761,007	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,187,075	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,948,082	$	48

*(See instructions.)

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,810,774	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,810,779	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,003,296	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,627,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 376,296	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,187,075	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,612,927	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,612,927	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	72,637	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 72,637	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	543	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 543	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ PRIOR YR EXPENSE	87,657	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 87,657	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,773,764	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,039,843	31
32	Health Care	4,344,560	32
33	General Administration	3,354,072	33
	B. Capital Expense		
34	Ownership	2,108,106	34
	C. Ancillary Expense		
35	Special Cost Centers	703,504	35
36	Provider Participation Fee	180,072	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,730,157	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,043,607	41
42	**Income Taxes**	(40,311)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,003,296	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,623	2,940	$ 143,646	$ 48.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,780	7,192	165,225	22.97	3
4	Licensed Practical Nurses	74,268	78,741	1,616,492	20.53	4
5	Nurse Aides & Orderlies	167,369	174,641	1,373,425	7.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,506	11,601	115,388	9.95	8
9	Activity Director					9
10	Activity Assistants	23,153	24,139	171,253	7.09	10
11	Social Service Workers	15,752	16,563	211,873	12.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,953	40,734	322,593	7.92	15
16	Dishwashers					16
17	Maintenance Workers	8,627	8,909	91,042	10.22	17
18	Housekeepers	44,321	46,696	341,014	7.30	18
19	Laundry	17,288	18,419	130,487	7.08	19
20	Administrator	2,486	2,531	177,917	70.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,021	23,882	259,524	10.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,112	5,340	53,355	9.99	31
32	Other Health C: MDS,nrsg clerical	11,922	12,358	232,182	18.79	32
33	Other(specify) Security	23,020	24,062	175,160	7.28	33
34	TOTAL (lines 1 - 33)	474,201	498,748	$ 5,580,576 *	$ 11.19	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 15,491	1-3	35
36	Medical Director	MONTHLY	6,000	9-3	36
37	Medical Records Consultant	MONTHLY	1,512	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	9,479	10-3	39
40	Physical Therapy Consultant	MONTHLY	8,322	10a-3	40
41	Occupational Therapy Consultant	MONTHLY	5,330	10a-3	41
42	Respiratory Therapy Consultant	MONTHLY	40,000	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	MONTHLY	4,608	11-3	44
45	Social Service Consultant	MONTHLY	4,046	12-3	45
46	Other(specify) DENTAL	MONTHLY	4,400	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 99,188		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL ROSEN	ADMIN	3	$ 177,917
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 177,917

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 521,500
PHILIP ESFORMES, INC	511,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,033,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		69,581
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 69,581

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 155,214
Unemployment Compensation Insurance		95,015
FICA Taxes		412,984
Employee Health Insurance		173,739
Employee Meals		12,627
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		4,253
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		39,202
CHICAGO HEAD TAX		12,984
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 906,018

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,275
Advertising: Employee Recruitment	1,500
Health Care Worker Background Check	5,719
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	2,273
TRUST/FRANCHISE/CONTRIB/ETC	6,436
LICENSES & PERMITS	4,381
DUES & SUBSCRIPTIONS	10,390
MGMT CO ALLOCATION	1,876
TRUST/FRANCHISE/CONTRIB/ETC	(6,436)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,273)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,141

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	1,760
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,760

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	2002	$ 10,449	3 YRS	$	$ 1,742	$ 3,483	$ 3,483	$ 1,741	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 10,449		$	$ 1,742	$ 3,483	$ 3,483	$ 1,741	$	$	$	$

Facility Name & ID Number PRESIDENTIAL PAVILION # 0045526 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $10,300**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,674** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **180,072**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,627** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients? **5%**

d. Have vehicle usage logs been maintained? **NO**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**

g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees